

Zonolite Attic Insulation Claims; (d) Non-Asbestos Claims; or (e) Medical Monitoring Claims even though such claims may or may not arise directly or indirectly as a result of exposure to asbestos or asbestos-containing products or the mining, milling or processing of vermiculite.

**“Zonolite Attic Insulation Claims”** are claims that relate, for example, to the cost of removal, diminution of property value or economic loss caused by the Zonolite Attic Insulation manufactured by the Debtors. Zonolite Attic Insulation is a loose-fill, non-roll vermiculite home attic insulation, which may contain naturally occurring asbestos. It was sold from the 1920/1930s to 1984. Zonolite may have a glittery granular appearance. The granules are shaped like a small nugget and expanded like an accordion and may have a silvery, gold translucent or brownish cast. After years in the attic, however, the granules may darken to black or gray. Zonolite may be found underneath subsequently installed insulation of other types such as rolled fiberglass insulation. Zonolite Attic Insulation Claims are those claims against, or any debt, obligation or liability of, one or more of the Debtors, whether in the nature of or sounding in tort, contract, warranty or any other theory of law or equity, relating to or arising by reason of, directly or indirectly, property damage, including, but not limited to, diminution in the value thereof, or environmental damage or economic loss caused or allegedly caused, directly or indirectly, by the Zonolite Attic Insulation sold, supplied, produced, specified, selected, distributed or in any way marketed by one of the Debtors -- and arising or allegedly arising, directly or indirectly, from acts or omissions of one or more of the Debtors, including, but not limited to, all claims, debts, obligations or liabilities for compensatory and punitive damages. The defined term “Zonolite Attic Insulation Claim” is not intended to include those claims separately defined herein as (a) Asbestos Personal Injury Claims; (b) Asbestos Property Damage Claims; (c) Settled Asbestos Claims; (d) Non-Asbestos Claims; or (e) Medical Monitoring Claims even though such claims may or may not arise directly or indirectly as a result of claims for property damage relating to Zonolite Attic Insulation.

**The Bar Date for filing NON-ASBESTOS CLAIMS, ASBESTOS PROPERTY DAMAGE CLAIMS AND MEDICAL MONITORING CLAIMS is March 31, 2003 at 4:00 p.m. Eastern Time.**

*Be sure to date the claim and place original signature of claimant or person making claim for creditor where indicated at the bottom of the claim form. Please type or print name of individual under the signature. Be sure all items are answered on the claim form. If not applicable, insert “Not Applicable”.*

**RETURN CLAIM FORM (WITH ATTACHMENTS, IF ANY) TO THE FOLLOWING CLAIMS AGENT FOR THE DEBTORS:**

Claims Processing Agent  
Re: W. R. Grace & Co. Bankruptcy  
P.O. Box 1620  
Faribault, MN 55021-1620

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# **W.R. GRACE & CO. ASBESTOS MEDICAL MONITORING PROOF OF CLAIM FORM**

*The United States Bankruptcy Court for the District of Delaware  
In re: W.R. Grace & Co., et al., Debtors, Case No. 01-01139 (JKF)  
(Jointly Administered)*

## **SUBMIT COMPLETED CLAIMS TO:**

**Claims Processing Agent  
Re: W.R. Grace & Co. Bankruptcy  
PO Box 1620  
Faribault, MN 55021-1620**

**For a complete list of the Debtors in this case, please see "The Debtors" section of the *General Instructions for Completing Proof of Claim Forms*. The Debtors in this case are collectively referred to in this document as "Grace".**

**If you have a current claim against Grace for medical monitoring, but not personal injury, due to alleged significant exposure to hazardous asbestos fibers as a result of the acts or omissions of Grace, THIS ASBESTOS MEDICAL MONITORING PROOF OF CLAIM FORM MUST BE RECEIVED ON OR BEFORE 4:00 P.M. EASTERN TIME ON MARCH 31, 2003, or you will be forever barred from asserting or receiving payment for your claim.**

**INSTRUCTIONS FOR FILING THE W. R. GRACE & CO.  
ASBESTOS MEDICAL MONITORING PROOF OF CLAIM FORM**

**WHO SHOULD USE THIS ASBESTOS MEDICAL MONITORING PROOF OF CLAIM FORM**

1. This Asbestos Medical Monitoring Proof of Claim Form (referred to in this document as the "Form") applies only to claims being made against Grace by or on behalf of those who have not as of the Claim Bar Date suffered any personal injury but who are alleging that Grace wrongfully caused them to be significantly exposed to hazardous asbestos fibers, that this exposure significantly increased the claimant's risk of contracting a serious latent disease, that medical monitoring could reasonably be expected to result in early detection of the onset and mitigation of the severity of such disease, and that because of this exposure it is necessary for the claimant to be examined by a physician or receive medical testing more often than he or she otherwise would.
2. The Bar Date does not apply to Asbestos Personal Injury Claims, Settled Asbestos Claims or Zonolite Attic Insulation Claims. Those claims will be subject to a separate claim submission process and should not be filed at this time.
3. This form should not be used for claims for an Asbestos Property Damage Claim or a Non-Asbestos Claim. Instead, separate specialized proof of claim forms for these claims should be completed.
4. Please do not distribute this form to others. Please call the Claims Processing Agent at 1-800-432-1909 to request additional forms if they are needed.

**GENERAL INSTRUCTIONS**

1. This form must be signed by the claimant or authorized agent of the claimant. THIS FORM MUST BE RECEIVED ON OR BEFORE 4:00 PM EASTERN TIME ON MARCH 31, 2003, or you forever will be precluded from asserting your claim(s) against or receiving payment from Grace. Return your completed form to the Claims Processing Agent, Re: W.R. Grace & Co. Bankruptcy, P.O. Box 1620, Faribault MN 55021-1620. If you are returning this form by mail, allow sufficient time so that this form is received on or before March 31, 2003. Forms that are postmarked before March 31, 2003 but received after March 31, 2003 will not be accepted. Only original forms will be accepted for filing. Forms transmitted by facsimile will not be accepted for filing.
2. If you cannot fit all information in any particular section or page, please make a copy of that page before filling it out and attach as many additional pages as needed.
3. This form must be filled out completely using BLACK or BLUE ink or may be typewritten.
  - Please print clearly using capital letters only.
  - Skip a box between words.
  - Do not write outside of the boxes or blocks.
  - Do not use a felt tip pen.
  - Do not bend or fold the pages of the form.
4. Because this form will be read by a machine, please print characters using the examples below. For optimum accuracy, please print in capital letters and avoid contact with the edge of the character boxes.
5. Mark check boxes with an "X" (example at right). 

NAME	HERE
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6. Be accurate and truthful. A Proof of Claim Form is an official court document that may be used as evidence in any legal proceeding regarding your claim. The penalty for presenting a fraudulent claim is a fine of up to \$500,000 or imprisonment for up to five years or both. 18 U.S.C. §§ 152 & 3571.
7. Make a copy of your completed Form to keep for your records. Send only original Forms to the Claims Agent at the following address: Claims Processing Agent, Re: W.R. Grace & Co. Bankruptcy  
P.O. Box 1620  
Faribault MN 55021-1620.
8. You will receive written notification of the proof of claim number assigned to this claim once it has been processed.

**PART I: CLAIMANT IDENTIFICATION****NAME:***First**Middle**Last**Jr/Sr/III***GENDER:** ☐ MALE ☐ FEMALE**SOCIAL SECURITY NUMBER:****BIRTH DATE:***Month Day Year***Residential Address:***Street Address**City**State**Zip Code**/Province**/Postal Code**Country (if not U.S.)***Day Time Telephone***Area Code***PART II: ATTORNEY INFORMATION**

*If an attorney is representing this claimant or the representative of this claimant, complete this section.  
(You do not need to be represented by an attorney to submit a claim.)*

**Law Firm Name****Attorney Name***First**MI**Last***Mailing Address for Claim-Related Correspondence***Street Address**City**State**Zip Code**/Province**/Postal Code**Country (if not U.S.)***Telephone Number***Area Code***Fax Number***Area Code***E-Mail Address**

3847101

**SERIAL #**

**PART III: Questions Applicable To Persons Claiming Exposure To Asbestos In The Libby, Montana Area (Lincoln County, Montana)**

**A. RESIDENCE/EMPLOYMENT INFORMATION**

- 1. Were you ever a resident of Lincoln County, Montana?**

☐ Yes☐ No

**During what period of time? What was/were your residential address(es) during each such period of time?**

**Start Date**

Figure 1 is a schematic diagram of the experimental setup. It shows a subject seated at a table, viewing a video screen. The screen displays a 2x2 grid of boxes. The top-left box is labeled '5000' and contains a small number of dots. The top-right box is labeled '1000' and contains a larger number of dots. The bottom-left box is labeled '500' and contains a larger number of dots. The bottom-right box is labeled '100' and contains a larger number of dots. The subject is looking at the screen through a video camera.

Month Year

**End Date**

The diagram shows a large square divided into four smaller squares by a horizontal and a vertical line. An arrow points from this large square to a set of four separate 1x1 squares.

Month Year

**Residential Address:**[illegible]

*Street Address*

[illegible]

City

Zip Code  
/Postal Code

**Start Date**

Figure 1

Month Year

**End Date**

Month Year

**Residential Address:**[illegible]

*Street Address*

[illegible]

City

Zip Code  
/Postal Code

### Start Date

[illegible]

Month Year

## End Date

Month Year

**Residential Address:**[illegible]

**Street Address**

[illegible]

City

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Zip Code  
/Postal Code

3 8 4 7 1 0 2

**SERIAL #**

2. List your jobs, employers and employment locations during each period of time in which you lived in Lincoln County.

1. Employment Dates:

From

--	--	--	--	--	--

Month Year

To

--	--	--	--	--	--

Month Year

2. Occupation:

description

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

3. Claimant's Employer

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4. Employment Location:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Street Address

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

City

Zip Code

/Postal Code

--	--	--	--	--	--

1. Employment Dates:

From

--	--	--	--	--	--

Month Year

To

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Month Year

2. Occupation:

description

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3. Claimant's Employer

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4. Employment Location:

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Street Address

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City

Zip Code

/Postal Code

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